APPENDIX C
DESCRIPTION OF HYBRID DIAGNOSIS RELATED GROUP (DRG) PROSPECTIVE PAYMENT SYSTEM

1. Hospitals Subject To Hybrid DRG Prospective Payment System

As described in Chapter 1000, Subsections 1001.1 and 1001.2, this reimbursement methodology is applicable to Georgia hospitals for admissions on or after October 9, 1997. It also applies to enrolled non-Georgia hospitals where noted.

2. Determination of Hybrid DRG Payment Rates

Effective with dates of admission on or after July 1, 1998, each hospital will be reimbursed for inpatient services based on a hybrid DRG prospective payment system. Within this system, an inpatient hospital claim may be reimbursed for operating cost using one of four payment calculations:

(a) Inlier Diagnosis Related Group (DRG)
(b) Outlier DRG
(c) Cost-to-Charge Ratio (CCR)

Exhibit C.1 is a list of each DRG and shows weights and cost thresholds used to evaluate claims for outlier status.

In addition to reimbursement for operating costs under one of the three methodologies above, hospitals will receive a hospital-specific per case add-on rate for capital costs (buildings and fixtures, and major movable equipment) and direct graduate medical education.

The basis for the determination of the payment rates under both the DRG and CCR methodologies is described below. All hospital-specific information is based on data from one of three sources:

(a) paid calendar year 1996 Georgia Medicaid paid claims data,

(b) for each DRG for which additional claims are needed, Georgia Medicaid paid claims data for state fiscal years 1995, 1996 and 1997 and

(b) the hospital's most recently audited Medicare cost report for hospital fiscal year 1995 or earlier as of January 30, 1998.

2.1 Calculation of the Inlier DRG Payment Hospital-Specific Base Rate (Operating Cost Reimbursement Only)

2.1.1 Calculation of the Peer Group Base Rate Before Stop Gain/Stop Loss

The peer group base rate is the average operating cost standardized for case mix of Inlier DRG cases across all cases in a peer group. For each case paid within the DRG methodology, the base rate will be multiplied by the appropriate DRG relative weight. This is the peer group base rate used in the calculation of the stop loss adjustment. If a hospital is not affected by the stop loss adjustment, the peer group base rate becomes the hospital-specific base rate.

(a) For each hospital's base year paid claims, the number of inlier cases that will be paid using the DRG methodology were identified.

(b) Inflation factors based the DRI hospital market basket minus 1 percent per year were calculated to inflate hospital claims from the claim's date of service to the midpoint of state fiscal year 1999.

(c) For each hospital's base year paid claims, the allowable charges for DRG inlier cases were identified.

(d) Allowable charges from Item 2.1.1(c) were inflated forward using the inflation factors from 2.1.1(b).

(e) For each hospital, the operating cost-to-charge ratio (CCR), which excludes capital and medical education, was obtained from the most recently audited Medicaid cost report. If the CCR was greater than 1, it was capped at 1 and then prorated between operating and capital.

(f) Total inlier DRG operating cost before adjustment for hospital case mix was obtained by multiplying Item 2.1.1(d) by Item 2.1.1(e).

(g) Per case inlier DRG operating cost before any adjustment for hospital case mix was calculated by dividing Item 2.1.1(f) by Item 2.1.1(a).

(h) Each hospital's case mix index was calculated based on base year inlier DRG claims.

(i) Total inlier DRG operating cost after adjustment for hospital case mix was then calculated by dividing Item 2.1.1(f) by Item 2.1.1(h).

(j) Per case inlier DRG operating cost after adjustment for hospital case mix was then calculated by dividing Item 2.1.1(i) by Item 2.1.1(a).

(k) Hospitals were assigned into one of three peer groups: statewide, specialty and pediatric.

(l) For all hospitals in the peer group, total inlier DRG cases from Item 2.1.1(a) above were summed across all hospitals in the peer group.

(m) For all hospitals in the peer group, the total inlier operating cost after any adjustment for hospital case mix (Item 2.1.1(i) above) have been summed across all hospitals in the peer group.

(n) Peer group inlier DRG operating cost per case were calculated by dividing 2.1.1(m) by Item 2.1.1(l). The result of this calculation was the peer group base rate before the hospital-specific stop loss adjustment.

2.1.2 Calculation of Hospital-Specific Stop Gain/Stop Loss Adjustment

A stop loss provision was implemented so that on a prospective basis the peer group base rates were adjusted to limit to 10% the amount that any hospital could lose on the DRG inlier operating cost component of the system.

(a) The estimated operating inlier DRG payment prior to add-on payment for capital and direct medical education was calculated as follows:

1. For each claim, the peer group base rate (Item 2.1.1(n)) was multiplied by the appropriate relative weight for that claim.

2. The result of 2.1.2(a)[1] summed across claims.

(b) The loss on the inlier DRG operating payment before the stop loss was calculated as the difference between the hospital-specific estimated operating payment for inlier DRG cases and total inlier DRG operating cost.

(c) For those hospitals not affected by the stop loss adjustment, the peer group base rate becomes the hospital-specific base rate amount. For those hospitals affected by the stop loss adjustment,

the hospital-specific base rate amount is the peer group base rate after the adjustment in (b) above.

(d) Operating payment for DRG inlier cases is equal to the hospital-specific base rate multiplied by the appropriate DRG relative weight.

2.2 Outlier DRG "Rates"

2.2.1 Criteria for Outlier DRG Calculation

(a) A case meets the outlier DRG criteria when it meets two (2) conditions:

1. It would normally be paid through the inlier DRG payment mechanism.

2. The operating cost of the case is more than the cost threshold stated in Exhibit C.1.

(b) In addition, a hospital must request that a claim be reviewed to assess manually if it meets the above two (2) conditions.

2.2.2 Calculation of Outlier DRG Claims and Payment

(a) In order to assess if a case meets outlier DRG criteria:

1. The total charge for a specific case will be multiplied by the hospital-specific operating CCR to calculate the cost per case.

2. The cost for the case will be compared to the outlier threshold amount for the DRG to which the case is assigned. (See Exhibit C.1 for DRG outlier thresholds)

(b) If a case qualifies as an outlier, it receives two payment components:

1. The claim will be paid the DRG base rate for the hospital multiplied by the appropriate DRG relative weight.

2 A supplemental amount equal to 90% of the difference between the dollar value of 2.2.2.(b)[1] above and the actual cost of the case.

2.3 CCR Reimbursement

2.3.1 Criteria for CCR Calculation

A case meets the CCR criteria if:

(a) The case is for a same day or one day stay (excluding delivery, false labor, death or a DRG identified for transfer cases), or

(b) the case is a transfer between hospitals for which claims are assigned to the same DRG.

Additionally, the CCR calculation amount must be less than the inlier, and if applicable, the outlier DRG payment amount. To receive consideration for any outlier payment, a hospital must request that a claim be reviewed.

2.3.2 Calculation of Operating Payments for CCR Cases

(a) Allowed charges multiplied by the hospital-specific CCR.

3. Determination of Capital and Graduate Medical Education (GME) Add-On Amounts

The basis for the determination of capital add-on amounts and GME add-on amounts are described below. All hospital-specific information is based on data from two sources:

(a) the hospital's most recently audited cost report for hospital fiscal year 1995 or before as of January 30, 1998 (for capital and GME add-on amounts)

(b) the hospital's capital surveys from the base year to November 15, 1997 (for capital add-on amounts only)

3.1 Calculation of the Capital Add-On Amount

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's total capital. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.

(b) Sum the hospital's capital costs (total buildings and fixtures) and capital costs (total major movable) from the cost report.

(c) Determine the Medicaid allocation of capital costs from the cost report by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total capital costs from the cost report (Item 3.1(b)).

(d) Determine the capital CCR by dividing the Medicaid allocation of capital costs (Item 3.1(c)) by the total allowed Medicaid charges for the cost report period.

(e) Calculate the base year capital costs by multiplying the capital CCR by the base year allowed charges.

(f) Calculate the preliminary capital costs per case by dividing the base year capital costs (Item 3.1(e)) by the base year number of cases.

(g) Sum the total amounts from the capital expenditure surveys.

(h) Determine the Medicaid allocation of capital costs from surveys by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total capital from surveys (Item 3.1(d)).

(i) Determine the survey rate of increase by diving Item 3.1(h) by item 3.1(c).

(j) Calculate the Capital Add-On Amount by multiplying item 3.1(f) by one plus item 3.1(i).

3.2 Calculation of the Direct Graduate Medical Education (GME) Add-On Amount

Only hospitals which have GME costs in the hospital's most recently audited Medicaid cost report receive the GME add-on amount.

(a) A Medicaid allocation ratio is used to apportion the Medicaid portion of the hospital's GME. The allocation ratio is the hospital's Medicaid inpatient costs divided by total hospital costs.

(b) Use the hospital's GME costs from the cost report.

(c) Determine the Medicaid allocation of GME costs from the cost report by multiplying the Medicaid allocation ratio (Item 3.1(a)) by total GME costs from the cost report (Item 3.1(b)).

(d) Determine the GME CCR by dividing the Medicaid allocation of GME costs (Item 3.1(c)) by the total allowed Medicaid charges for the cost report period.

(e) Calculate the base year GME costs by multiplying the capital CCR by the base year allowed charges.

(f) Multiply the Medicaid GME amount (Item 3.1(e)) by the DRI inflation factor. This will yield the inflated Medicaid GME amount.

(e) Divide the total Medicaid allocation of GME (Item 3.1(f)) by the Medicaid discharges from the base year. This will yield the Medicaid GME amount per discharge.

4. Disproportionate Share Hospitals (DSH) Payment

4.1 Federal regulations require that methods and standards used to determine payment rates must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. In the month of June each year, the Department designates enrolled Georgia hospitals as disproportionate share based upon the definition below, review of annual disproportionate share hospital surveys, review of hospital cost reports, and the requirements of Section 4112 of the Omnibus Reconciliation Act of 1987. On or around June 30 of each year, hospitals will be notified of their designation as disproportionate share and the effective date thereof. A provider will not be designated a disproportionate share hospital at any other time during the year. Should a hospital lose its disproportionate share designation, it must wait until the next disproportionate share hospital designation period (June) to again be considered for the designation. A hospital serving a disproportionate number of low-income patients with special needs is defined as:

(a) One whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments; or

(b) One which has a low-income inpatient utilization rate exceeding 25 percent of total revenue; or

(c) One with total covered Medicaid charges for paid claims, inpatient and outpatient, exceeding 15 percent of total revenue; or

(d) A non-State hospital with the largest number of Medicaid admissions in its Metropolitan Statistical Area; or

(e) A children's hospital; or

(f) A hospital that has been designated a Regional Perinatal Center by the Department of Human Resources; or

(g) A Georgia hospital that has been designated a Medicare rural referral center and a Medicare disproportionate share hospital provider by its fiscal intermediary or a Georgia hospital which is a Medicare rural referral center and which has 10% or more Medicaid patient days and 30% or more Medicaid deliveries; or

(h) A State-owned and operated hospital administered by the Board of Regents.

(i) Effective with payment adjustments made on and after May 15, 1997, a public hospital with less than 100 beds located in a non-metropolitan statistical area (non-MSA) with an inpatient Medicaid utilization rate of at least 1%. Inpatient Medicaid utilization rate is defined as the ratio of Medicaid inpatient days to total inpatient days.

No hospital may be designated a disproportionate share hospital provider unless the hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid recipients. This requirement does not apply to a hospital of which the inpatients are predominately individuals under 18 years of age or to a hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987. In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

No hospital can be deemed or defined as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate of at least 1% and meets at least one of the nine other established DSH criteria.

For public hospitals, the DSH payments may not exceed the costs incurred during the year of furnishing hospital services by the hospital to Medicaid patients and to patients who have no health insurance (or other source of third party coverage) for services provided during the year. Payments made by a state or unit of local government to a hospital for indigent patients shall not be considered a source of third party payment.

4.2 Enrolled Georgia disproportionate share hospitals which meet one of DSH criteria one through eight will receive a payment adjustment in the form of an intensity allowance of 1 percent per year (other than base year) added to the trend factor. Hospitals which have a Medicaid inpatient utilization rate at least one standard deviation above the mean statewide rate will have an additional payment adjustment calculated which is proportional to their rates in excess of the standard deviation.

4.3 Effective with admissions on and after July 1, 1990, disproportionate share hospital (DSH) providers which directly received grant funds in 1989 from the Department of Human Resources' (DHR) Regionalized Infant Intensive Care Program will have their rates revised to include an additional DSH payment adjustment. These hospitals provide intensive care services to a disproportionate number of high risk neonates and incur significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs for neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department. Effective with admissions on and after July 1, 1991, subject to the availability of funds, these hospitals wills receive monthly lump-sum DSH payment adjustments instead of adjustments to their per case rates.

4.4 Effective with dates of service of July 1, 1991, and after, subject to the availability of funds, the Department will make quarterly payment adjustments to disproportionate share teaching hospitals which participate in the Family Practice or Residency Grants Program administered by the Joint Board of Family Practice (JBFP). These hospitals operate post-graduate training programs for physicians preparing to enter family practice and other medical specialties and incur significant costs associated with the operation of such training programs. The payment will include reported graduate medical education costs for these programs as determined by the JBFP and reviewed and accepted by the Department.

4.5 Effective for dates of admission of January 1, 1991, and after, the Department will make an additional disproportionate share hospital (DSH) adjustment to recognize the significant medical education and other costs incurred by a state-owned and operated teaching hospital which are only partially reimbursed by the Department. The payment adjustment amount is calculated by increasing the hospital's per case reimbursement rate, exclusive of other DSH adjustments, up to the Medicare upper limit rate.

4.6 Effective with dates of service of July 1, 1991, and after, subject to the availability of funds, the Department will make a monthly disproportionate share payment adjustment to those DSH providers which contract with the Department of Human Resources for services provided in

the following programs: AIDS Clinic, Poison Control Center, Genetics/Sickle Cell Screening and Maternal and Infant Health Services. The DSH payments will begin on or after July 16, 1991, and will be made to reimburse for significant costs incurred in the provision of program services. The payments will be reasonably related to cost or volume of services provided by these DSH providers to Medicaid or other indigent patients.

4.7 Effective for dates of admission of July 1, 1994, and after, the DSH provider which was designated the sixth tertiary center to receive grant funds from the Department of Human Resources' Regionalized Infant Intensive Care Program, subject to the availability of funds, will receive monthly lump-sum payment adjustments. This hospital provides intensive care services to a disproportionate number of high risk neonates and incurs significant unreimbursed costs associated with the provision of such services. The payment adjustment will include reported unreimbursed costs for neonatal intensive care and related transportation services as determined by DHR and reviewed and accepted by the Department.

4.8 The Department will make a payment adjustment to disproportionate share hospitals which agree to comply with Departmental Rule 350-6-.03(3). The payment adjustment will be calculated as outlined below.

(a) Calculate a payment adjustment percentage for each DSH using the steps below:

- o Add 50% for each DSH provider.
- o Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- o Add 12.5% for each additional DSH criterion that a hospital meets.
- o Add 0-50% proportionally based on the percentage of Medicaid births for each hospital.
- o Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.
- o Add 0-100% proportionally for hospitals admissions greater than 1000.